A bill to be entitled

An act relating to Medicaid managed care; amending s. 408.7056, F.S.; specifying which health plan entities are subject to the subscriber assistance program; amending s. 409.912, F.S.; authorizing the Agency for Health Care Administration to extend or modify certain contracts with behavioral health care providers under specified circumstances; removing the expiration of the authority of the agency to impose fines against entities under contract with the department under specified circumstances; amending s. 409.9122, F.S.; directing the agency to calculate a medical loss ratio for managed care plans under specified circumstances and providing the method of calculation; amending s. 409.961, F.S.; specifying that contracts necessary to administer the Medicaid program are not rules and are not subject to ch. 120, F.S., the Administrative Procedure Act; amending s. 409.962, F.S.; including certain Medicare plans in the definition of the term "comprehensive long-term care plan"; including certain Medicare plans in the managed medical assistance program by amending the definition of the term "eligible plan"; amending s. 409.966, F.S.; modifying a preference for plans with in-state operations; revising a definition; amending s. 409.967, F.S.; limiting the penalty that a plan must pay if it leaves a region before the end of the contract term; directing the agency to calculate a medical loss ratio for managed care plans under specified circumstances

and providing the method of calculation; amending s. 409.973, F.S.; requiring a managed care plan to inform the enrollee of the importance of having a primary care provider; amending s. 409.974, F.S.; revising requirements for participation by specialty plans; revising requirements for participation by certain Medicare plans; requiring contracts to meet certain standards; setting enrollment requirements; amending s. 409.981, F.S.; modifying requirements for participation by Medicare Advantage Special Needs Plans; requiring contracts to meet certain standards; establishing enrollment requirements; amending s. 627.602, F.S.; applying federal internal grievance procedures to certain health insurance policies; providing exceptions; creating s. 627.6513, F.S.; applying federal internal grievance procedures to certain group health insurance policies; providing exceptions; creating s. 641.312, F.S.; authorizing the Office of Insurance Regulation to adopt rules to administer the federal procedures; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Effective May 12, 2012, subsection (15) is added to section 408.7056, Florida Statutes, to read:

408.7056 Subscriber Assistance Program.—

(15) This section applies only to prepaid health clinics certified under chapter 641, Florida Healthy Kids plans, and

health plan health insurance policies or health maintenance contracts that meet the requirements of 45 C.F.R. s. 147.140, but only if the health plan does not elect to have all of its health insurance policies or health maintenance contracts subject to applicable internal grievance and external review processes by an independent review organization. A health plan must notify the agency in writing if it elects to have all of its health insurance policies or health maintenance contracts subject to such external review.

Section 2. Paragraph (b) of subsection (4) and subsection (21) of section 409.912, Florida Statutes, are amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician’s opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute

inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid

beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c) or paragraph (d), and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements

related to children in the department's care or custody before enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 5., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and are subject to this paragraph. Each entity must offer a sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph must

require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations and capitated provider service networks, to be expended for the provision of behavioral health care services. If the managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the plan with a certification letter indicating the amount of capitation paid during each calendar year for behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. The agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. Except as provided in subparagraph 5., the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance

organization, a provider service network authorized under paragraph (d), or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations are eligible to compete. Managed care plans contracting with the agency under subsection (3) or paragraph (d) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts must be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services

through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in area 11 who are assigned to MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

3. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider may not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

4. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

5. All Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, that are open for child welfare services in the statewide automated child welfare information system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies through a single agency or formal agreements among several agencies. The agency shall work with the specialty plan to develop clinically effective, evidence-based alternatives as

a downward substitution for the statewide inpatient psychiatric program and similar residential care and institutional services. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency may seek federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the statewide automated child welfare information system and who reside in AHCA area 10 shall be enrolled in a capitated provider service network or other capitated managed care plan, which, in coordination with available community-based care providers specified in s. 409.1671, shall provide sufficient medical, developmental, and behavioral health services to meet the needs of these children.

Effective July, 1, 2012, in order to ensure continuity of care, the agency is authorized to extend or modify current contracts based on current service areas or on a regional basis, as determined appropriate by the agency, with comprehensive behavioral health care providers as described in this paragraph during the period prior to its expiration. This paragraph expires October 1, 2014.

(21) The agency may impose a fine for a violation of this section or the contract with the agency by a person or entity that is under contract with the agency. With respect to any nonwillful violation, such fine shall not exceed $2,500 per

violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of this section or the contract with the agency, the agency may impose a fine upon the entity in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action. ~~This subsection expires October 1, 2014.~~

Section 3. Subsection (21) is added to section 409.9122, Florida Statutes, to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.—

(21) If required as a condition of a waiver, the agency may calculate a medical loss ratio for managed care plans. The calculation shall utilize uniform financial data collected from all plans and shall be computed for each plan on a statewide basis. The method for calculating the medical loss ratio shall meet the following criteria:

(a) Except as provided in paragraphs (b) and (c), expenditures shall be classified in a manner consistent with 45 C.F.R. part 158.

(b) Funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions shall be classified as medical expenditures, provided the funding is sufficient to sustain the position for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients.

(c) Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period.

Section 4. Section 409.961, Florida Statutes, is amended to read:

409.961 Statutory construction; applicability; rules.—It is the intent of the Legislature that if any conflict exists between the provisions contained in this part and in other parts of this chapter, the provisions in this part control. Sections 409.961–409.985 apply only to the Medicaid managed medical assistance program and long-term care managed care program, as provided in this part. The agency shall adopt any rules necessary to comply with or administer this part and all rules necessary to comply with federal requirements. In addition, the department shall adopt and accept the transfer of any rules necessary to carry out the department's responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility and for ensuring compliance with and administering this part, as those rules relate to the department's responsibilities, and any other provisions related to the department's responsibility for the determination of Medicaid eligibility. Contracts with the agency and a person or entity, including Medicaid providers and managed care plans, necessary to administer the Medicaid program are not rules and are not subject to chapter 120.

Section 5. Subsections (4) and (6) of section 409.962, Florida Statutes, are amended to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(4) "Comprehensive long-term care plan" means a managed care plan, including a Medicare Advantage Special Needs Plan organized as a preferred provider organization, provider-sponsored organization, health maintenance organization, or coordinated care plan, that provides services described in s. 409.973 and also provides the services described in s. 409.98.

(6) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(4)(d) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391 and~~. For purposes of the long-term care managed care program, the term also includes~~ entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

Section 6. Paragraph (c) of subsection (3) of section 409.966, Florida Statutes, is amended to read:

409.966 Eligible plans; selection.—

(3) QUALITY SELECTION CRITERIA.—

(c) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive

and provide the best value to the state. Preference shall be given to plans that:

1. Have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards established pursuant to s. 409.967(2)(b).

2. Have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan.

3. Are organizations that are based in and perform operational functions in this state, in-house or through contractual arrangements, by staff located in this state. Using a tiered approach, the highest number of points shall be awarded to a plan that has all or substantially all of its operational functions performed in the state. The second highest number of points shall be awarded to a plan that has a majority of its operational functions performed in the state. The agency may establish a third tier; however, preference points may not be awarded to plans that perform only community outreach, medical director functions, and state administrative functions in the state. For purposes of this subparagraph, operational functions include corporate headquarters, claims processing, member services, provider relations, utilization and prior authorization, case management, disease and quality functions, and finance and administration. For purposes of this subparagraph, the term "corporate headquarters" ~~"based in this state"~~ means ~~that~~ the ~~entity's~~ principal office of ~~is in this state and~~ the organization, which may not be ~~plan is not~~ a subsidiary, directly or indirectly through one or more subsidiaries of, or a joint venture with, any other entity whose

principal office is not located in the state.

4. Have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

5. Have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings.

6. Have a claims payment process that ensures that claims that are not contested or denied will be promptly paid pursuant to s. 641.3155.

Section 7. Paragraph (h) of subsection (2) of section 409.967, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(h) *Penalties.*—

1. Withdrawal and enrollment reduction.—Managed care plans that reduce enrollment levels or leave a region before the end of the contract term must reimburse the agency for the cost of enrollment changes and other transition activities. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a <u>per-enrollee</u> ~~per enrollee~~ penalty of up to 3 months' payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan,

whichever occurs first. In addition to payment of costs, all other departing plans must pay a penalty of 25 percent of that portion of the minimum surplus maintained ~~requirement~~ pursuant to s. 641.225(1) which is attributable to the provision of coverage to Medicaid enrollees. Plans shall provide at least 180 days' notice to the agency before withdrawing from a region. If a managed care plan leaves a region before the end of the contract term, the agency shall terminate all contracts with that plan in other regions~~,~~ pursuant to the termination procedures in subparagraph 3.

2. Encounter data.—If a plan fails to comply with the encounter data reporting requirements of this section for 30 days, the agency must assess a fine of $5,000 per day for each day of noncompliance beginning on the 31st day. On the 31st day, the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

3. Termination.—If the agency terminates more than one regional contract with the same managed care plan due to noncompliance with the requirements of this section, the agency shall terminate all the regional contracts held by that plan. When terminating multiple contracts, the agency must develop a plan to provide for the transition of enrollees to other plans, and phase in ~~phase-in~~ the terminations over a time period sufficient to ensure a smooth transition.

(4) MEDICAL LOSS RATIO.—If required as a condition of a waiver, the agency may calculate a medical loss ratio for managed care plans. The calculation shall use uniform financial data collected from all plans and shall be computed for each

plan on a statewide basis. The method for calculating the medical loss ratio shall meet the following criteria:

(a) Except as provided in paragraphs (b) and (c), expenditures shall be classified in a manner consistent with 45 C.F.R. part 158.

(b) Funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions shall be classified as medical expenditures, provided the funding is sufficient to sustain the position for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients.

(c) Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period.

Section 8. Subsection (4) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(4) PRIMARY CARE INITIATIVE.—Each plan operating in the managed medical assistance program shall establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan shall:

(a) Provide information to each enrollee on the importance of and procedure for selecting a primary care provider ~~physician~~, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider.

(b) If the enrollee was not a Medicaid recipient before enrollment in the plan, assist the enrollee in scheduling an appointment with the primary care provider. If possible the appointment should be made within 30 days after enrollment in the plan. For enrollees who become eligible for Medicaid between January 1, 2014, and December 31, 2015, the appointment should be scheduled within 6 months after enrollment in the plan.

(c) Report to the agency the number of enrollees assigned to each primary care provider within the plan's network.

(d) Report to the agency the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment.

(e) Report to the agency the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

Section 9. Subsection (3) of section 409.974, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

409.974 Eligible plans.—

(3) SPECIALTY PLANS.—Participation by specialty plans shall be subject to the procurement requirements ~~and regional plan number limits~~ of this section. The aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the total enrollees of that region. ~~However, a specialty plan whose target population includes no more than 10 percent of the enrollees of that region is not subject to the regional plan number limits of this section.~~

(5) MEDICARE PLANS.—Participation by a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-

sponsored Organization, Medicare Advantage Health Maintenance Organization, Medicare Advantage Coordinated Care Plan, or Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency that is consistent with the Medicare Improvement for Patients and Providers Act of 2008, Pub. L. No. 110-275. Such plans are not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits as of the date that the invitation to negotiate is issued. Otherwise, such plans are subject to all procurement requirements.

Section 10. Subsection (5) of section 409.981, Florida Statutes, is amended to read:

409.981 Eligible long-term care plans.—

(5) MEDICARE ADVANTAGE SPECIAL NEEDS PLANS.—Participation by a ~~Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or~~ Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency that is consistent with the Medicare Improvement for Patients and Providers Act of 2008, Pub. L. No. 110-275. Such plans are ~~and~~ not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits as of the date the invitation to negotiate is issued ~~deemed dually eligible for Medicaid and Medicare services~~. Otherwise, ~~Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and~~ Medicare Advantage Special Needs Plans are subject to all procurement requirements.

Section 11. Effective May 12, 2012, paragraph (h) is added to subsection (1) of section 627.602, Florida Statutes, to read:

627.602 Scope, format of policy.—

(1) Each health insurance policy delivered or issued for delivery to any person in this state must comply with all applicable provisions of this code and all of the following requirements:

(h) Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances. This paragraph does not apply to a health insurance policy that is subject to the subscriber assistance program under s. 408.7056 or to the types of benefits or coverages provided under s. 627.6561(5)(b)-(e) issued in any market.

Section 12. Effective May 12, 2012, section 627.6513, Florida Statutes, is created to read:

627.6513 Scope.—Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances, apply to all group health insurance policies issued under this part. This section does not apply to a group health insurance policy that is subject to the subscriber assistance program in s. 408.7056 or to the types of benefits or coverages provided under s. 627.6561(5)(b)-(e) issued in any market.

Section 13. Effective May 12, 2012, section 641.312, Florida Statutes, is created to read:

641.312 Scope.—The Office of Insurance Regulation may adopt rules to administer the provisions of the National Association of Insurance Commissioners' Uniform Health Carrier External

Review Model Act, issued by the National Association of Insurance Commissioners and dated April 2010. This section does not apply to a health maintenance contract that is subject to the subscriber assistance program under s. 408.7056 or to the types of benefits or coverages provided under s. 625.6561(5)(b)-(e) issued in any market.

Section 14. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2012.